THE OFFICE OF THE INSPECTOR GENERAL

DMHMRSAS

NORTHERN VIRGINIA TRAINING CENTER

SNAPSHOT INSPECTION

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INSPECTOR GENERAL

OIG REPORT # 55-02

EXECUTIVE SUMMARY

A Snapshot Inspection was conducted at Northern Virginia Training Center in Fairfax, Virginia during February 25, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

NVTC was the first of five facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services to have been found to be in violation of the Civil rights for Institutionalized Persons Act by the United States Department of Justice. Many improvements have occurred at this facility as a result.

This snapshot inspection revealed the following: adequate staffing were present, a broad array of treatment activities were available to residents, especially during weekday hours, and the grounds are well maintained. Residential areas were clean, comfortable and well maintained, with some units being more homelike and less institutional than others.

Recommendations for performance improvement were made in several areas, including a review of current security policy and staff in-service human rights training is warranted.

Facility: Northern Virginia Training Center

Fairfax, Virginia

Date: February 25, 2002

Type of Inspection: Snapshot Inspection / Unannounced

Reviewers: Anita S. Everett, M.D.

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Purpose of the Inspection: To conduct an inspection of the general environmental conditions, staffing patterns and activities of the patients.

Sources of Information: Interviews were conducted with clinical and direct care staff. Documentation reviews, included but were not limited to; patient(s) clinical records, medication records, staff schedule sheets, program descriptions and activity/program scheduled, and selected policies and procedures. Activities and staff/patient interactions were observed during a tour of selected residential areas in the facility.

GENERAL ENVIRONMENTAL ISSUES

Finding 1.1: Overall, the cottages that the team visited were clean, comfortable and well maintained.

Background: Members of the OIG staff toured the following units: 1A, 5C, 6C, 3A, 3C, and 3D, during second shift. Observations illustrated that staff continue to work towards providing a clean and well-maintained environment. This facility is one of three training centers built in the 1970's. The environment of this facility is institutional in appearance

due to the era of its design. Efforts were noted in decorating the living areas to meet individual preferences of each unit. The day areas contained comfortable, appropriate furniture for the population served and the bedrooms allowed for the display of personal items such as pictures, bed sets, stuffed animals, and family memorabilia. The facility is attempting to establish an internship with an area school of interior decorating in order to enhance a more homelike environment within the limitations of the facility design.

Recommendation: Continue to provide an environment that meets the clinical and personal needs of the residents in each unit. Pursue the establishment of the intern opportunity.

Finding 1.2: The recently established visitors policy regarding security practices was inconsistently applied in the cottages toured.

Background: Members of the OIG inspection team toured units, 1A and 5C, during the dinner hour. Upon entering both units, the team was required to sign in and out and wear appropriate identification while on onsite. This practice was in contrast to the return evening visit of the same date. The inspection team returned and went first to the easiest accessible building for the public, Building 3. This building is located closest to the public parking lot. The team entered the building and noted that there were no staff were immediately present. There was a sign that directed visitors to the "Nurses Station" to sign in. The team followed this instruction and went to unit 3A, but could not locate any personnel in the nursing station. The OIG team proceeded to walk onto the unit and was approached by a staff member that did not aggressively seek the identification of the team members. The team members volunteered identification and were asked to sign in, but were not provided with visitor badges. The team also visited units 3C and 3D. The team was not required by either of these units to sign in because the team notified unit staff of the original sign-in on unit 3A. This was not questioned even though badges were being worn. Team members were informed that signing out was not required because of the signing in process.

After visiting Building 3, the OIG team visited Unit 6C. This is a "locked" behavioral unit. The team entered the building and followed the instructions of the posted sign to sign in the nurses station. Upon arriving at Unit 6C, there was no personnel in the nursing station. The team entered into the nursing station via an unlocked part of the unit that was unoccupied at the time, despite a note on the door indicating that the nurses station should be locked at all times. The OIG team member then let the remaining members in where they got the attention of nursing staff. The nurse did ask the OIG for identification and then called security. Security informed the OIG team that they needed to come to the administration building to sign-in. This process is different than that noted in the visitors policy, which requires first the notification of the roving team leader, whose responsibility it is to escort visitors to the security for sign-in and badges. After interviewing staff, the OIG team left the grounds without ever seeing any security personnel.

Recommendation: It is recognized that this is a new policy. Additional training for staff regarding the appropriate protocol for the identification and tracking of visitors to the facility is warranted.

STAFFING ISSUES

Finding 2.1: There is inconsistent information regarding the projected completion of the new human rights regulations training for direct care staff.

Background: The new human rights regulations went into effect in November 2001. NVTC administrative staff related that the responsibility for the completion of training regarding the new regulations are in the process of shifting from the human rights advocates to the facility training office. NVTC staff related that training would occur for new staff at the time of orientation and then at the time of annual recertification. Team members were informed that staff hired just prior to the November implementation date would be trained at their annual training date, almost a year later. Central Office notified the OIG that scheduled training of all facility staff is expected to be completed by June 2002, as a phased in process.

Recommendation: The new human rights regulations serve as an important framework for assuring that residents are treated with dignity and respect free from neglect, abuse and exploitation. As staff are held accountable to the regulations, timely training is imperative. Facility staff in conjunction with the Central Office needs to establish a timeframe for the successful completion of this important training.

Finding 2.2: Staffing patterns were adequate for meeting residents' basic care and active treatment needs.

Background: Observation of the staffing complement on the Monday evening shift during the inspection was that it was adequate for providing the type of daily living care that is typically undertaken in the evenings. OIG team members witnessed residents being assisted during the dinner meal and other evening activities, such as bathing, toileting, range of motion activities and snack time.

Staffing patterns were as follows:

Unit 3A	18 residents and 4 staff
Unit 3C	19 residents and 6 staff
Unit 3D	16 residents and 5 staff
Unit 1A	15 residents and 5 staff

Unit 6C	5 residents and 2 staff
Unit 5C	16 residents and 5 staff

The team was informed that the staff patterns during the evenings for the aforementioned areas were consistent with those observed during the inspection.

Recommendation: Continue to provide an appropriate level of staffing based on acuity needs of the residents.

ACTIVITY OF PATIENTS

Finding 3.1: The evening activities observed were designed for the basic care and meeting daily living activities of the residents.

Background: Tours of the units were completed during the normal bed time for the residents. Observations of the interactions between the staff and residents and information provided through staff interviews, demonstrated that the activities were adequate for providing the type of daily living care that is typically undertaken in the evenings. Staff explained that most of the residents were in bed by between 8:30 pm and 9:00 pm as “wake up” usually occurs around 5:00 am in order for residents to be ready for their structured day activities.

Recommendation: Continue to assess the needs of each client and offer appropriate activities to meet those needs.